FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041228

Facility Name: ROYAL HEIGHTS NRSG AND REHAB CENTER LLC

Address: 900 ROYAL HEIGHTS RD (Number) BELLEVILLE (City) 62226 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 235-6133 **Fax #** (618) 235-9860

IDPA ID Number: 371347517001

Date of Initial License for Current Owners: 10/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	234	Skilled (SNF)	234	85,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	234	TOTALS	234	85,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,198		1,878	5,076	8
9	SNF/PED					9
10	ICF	50,109	2,903		53,012	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,307	2,903	1,878	58,088	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.01%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 1488

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CE # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	196,309	38,713	7,831	242,853		242,853		242,853			1
2	Food Purchase		264,556		264,556	(7,512)	257,044	(132)	256,912			2
3	Housekeeping	222,192	14,794		236,986		236,986		236,986			3
4	Laundry	80,290	35,388		115,678		115,678		115,678			4
5	Heat and Other Utilities			156,470	156,470		156,470		156,470			5
6	Maintenance	114,263	19,613	84,833	218,709		218,709		218,709			6
7	Other (specify):*											7
8	**TOTAL General Services**	613,054	373,064	249,134	1,235,252	(7,512)	1,227,740	(132)	1,227,608			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	1,213,054	103,328	6,890	1,323,272		1,323,272	34,660	1,357,932			10
10a	Therapy		1,936	17,880	19,816		19,816		19,816			10a
11	Activities	64,163			64,163		64,163		64,163			11
12	Social Services	130,148		3,715	133,863		133,863		133,863			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,767	5,767			15
16	**TOTAL Health Care and Programs**	1,407,365	105,264	38,485	1,551,114		1,551,114	40,427	1,591,541			16
	C. General Administration											
17	Administrative	46,333		368,358	414,691		414,691	(218,496)	196,195			17
18	Directors Fees											18
19	Professional Services			45,803	45,803		45,803	2,779	48,582			19
20	Dues, Fees, Subscriptions & Promotions			30,187	30,187		30,187	(6,733)	23,454			20
21	Clerical & General Office Expenses	51,172	25,882	93,133	170,187		170,187	12,441	182,628			21
22	Employee Benefits & Payroll Taxes			345,213	345,213	7,512	352,725		352,725			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,388	1,388		1,388	(196)	1,192			24
25	Other Admin. Staff Transportation			2,337	2,337		2,337	6,691	9,028			25
26	Insurance-Prop.Liab.Malpractice			249,361	249,361		249,361	828	250,189			26
27	Other (specify):*							20,473	20,473			27
28	**TOTAL General Administration**	97,505	25,882	1,135,780	1,259,167	7,512	1,266,679	(182,213)	1,084,466			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,117,924	504,210	1,423,399	4,045,533		4,045,533	(141,918)	3,903,615			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC #0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			24,764	24,764		24,764	116,156	140,920			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,208	55,208		55,208	207,679	262,887			32
33	Real Estate Taxes			80,500	80,500		80,500	(3,564)	76,936			33
34	Rent-Facility & Grounds			277,680	277,680		277,680	(265,797)	11,883			34
35	Rent-Equipment & Vehicles			20,202	20,202		20,202	5,953	26,155			35
36	Other (specify):*							9,041	9,041			36
37	**TOTAL Ownership**			458,354	458,354		458,354	69,468	527,822			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,138	29,283	57,421		57,421		57,421			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,115	128,115		128,115		128,115			42
43	Other (specify):*			1,741	1,741		1,741	(1,741)				43
44	**TOTAL Special Cost Centers**		28,138	159,139	187,277		187,277	(1,741)	185,536			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,117,924	532,348	2,040,892	4,691,164		4,691,164	(74,191)	4,616,973			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,066	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(132)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,339)	21		18
19	Entertainment	(445)	20		19
20	Contributions	(180)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,820)	21		24
25	Fund Raising, Advertising and Promotional	(6,152)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,773)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (66,775)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(7,416)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (7,416)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (74,191)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ROYAL HEIGHTS NRSG AND REHAB CENTER LLC

ID# 0041228

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (3,856)	21	1
2	MARKETING EXPENSE	(1,741)	43	2
3	VENDOR LATE FEES	(886)	32	3
4	REAL ESTATE TAX LATE FEES	(3,564)	33	4
5	VEHICLE LEASE LATE FEES	(62)	35	5
6	LOAN FINANCE COSTS	(664)	36	6
7				7
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9				9
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(132)											(132)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance													6
7	Other (specify):*													7
8	**TOTAL General Services**	(132)											(132)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			34,660									34,660	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,767									5,767	15
16	**TOTAL Health Care and Programs**			40,427									40,427	16
	C. General Administration													
17	Administrative			(218,496)									(218,496)	17
18	Directors Fees													18
19	Professional Services			2,779									2,779	19
20	Fees, Subscriptions & Promotions	(6,777)		44									(6,733)	20
21	Clerical & General Office Expenses	(71,015)	151	83,305									12,441	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			(196)									(196)	24
25	Other Admin. Staff Transportation			6,691									6,691	25
26	Insurance-Prop.Liab.Malpractice			828									828	26
27	Other (specify):*			20,473									20,473	27
28	**TOTAL General Administration**	(77,792)	151	(104,572)									(182,213)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,924)	151	(64,145)									(141,918)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	18,066	96,831	1,259									116,156	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(886)	208,562	3									207,679	32
33	Real Estate Taxes	(3,564)											(3,564)	33
34	Rent-Facility & Grounds		(277,679)	11,882									(265,797)	34
35	Rent-Equipment & Vehicles	(62)		6,015									5,953	35
36	Other (specify):*	(664)	9,705										9,041	36
37	**TOTAL Ownership**	12,890	37,419	19,159									69,468	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,741)											(1,741)	43
44	**TOTAL Special Cost Centers**	(1,741)											(1,741)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(66,775)	37,570	(44,986)									(74,191)	45

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				BELLEVILLE HEALTHCARE		BUILDING
				PROPERTIES	BELLEVILLE	PARTNERSHIP

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 277,679	BELLEVILLE HEALTHCARE PROPERTIES	100.00%	$	$ (277,679)	1
2	V	36	AMORTIZATION-LOAN COSTS		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	9,041	9,041	2
3	V	21	BANK CHARGES		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	151	151	3
4	V	30	DEPRECIATION		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	96,831	96,831	4
5	V	32	INTEREST EXPENSE-MORTGAGE		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	208,562	208,562	5
6	V	36	LOAN REFINANCE COSTS		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	664	664	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 277,679			$ 315,249	$ * 37,570	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. SAL.-NON OWNER	$	HEALTHCARE MNGMNT. ASSOC.	100.00%	$ 41,956	$ 41,956	15
16	V	19	PROFESSIONAL FEES		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,779	2,779	16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE MNGMNT. ASSOC.	100.00%	44	44	17
18	V	21	CLERICAL & GENERAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	53,725	53,725	18
19	V	24	SEMINAR		HEALTHCARE MNGMNT. ASSOC.	100.00%	(196)	(196)	19
20	V	25	TRAVEL		HEALTHCARE MNGMNT. ASSOC.	100.00%	6,691	6,691	20
21	V	26	INSURANCE		HEALTHCARE MNGMNT. ASSOC.	100.00%	828	828	21
22	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	11,613	11,613	22
23	V	30	DEPRECIATION		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,259	1,259	23
24	V	34	OFFICE SPACE		HEALTHCARE MNGMNT. ASSOC.	100.00%	11,882	11,882	24
25	V	32	INTEREST		HEALTHCARE MNGMNT. ASSOC.	100.00%	3	3	25
26	V	35	EQUIPMENT RENTAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	6,015	6,015	26
27	V	10	NURSING SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	34,660	34,660	27
28	V	15	EMP. BEN. - HEALTH CARE		HEALTHCARE MNGMNT. ASSOC.	100.00%	5,767	5,767	28
29	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	29,580	29,580	29
30	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE MNGMNT. ASSOC.	100.00%	4,288	4,288	30
31	V								31
32	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	7,414	7,414	32
33	V	17	ADMIN. SALARY - D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	16,492	16,492	33
34	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,615	1,615	34
35	V	27	EMP. BEN.-D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,957	2,957	35
36	V								36
37	V	17	MANAGEMENT FEE	284,358	HEALTHCARE MNGMNT. ASSOC.	100.00%		(284,358)	37
38	V								38
39	Total			$ 284,358			$ 239,372	$ * (44,986)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CI # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ERIC ROTHNER	RELATIVE	ADMIN	0.00%	SEE ATTACHED	0.78	1.08%	MGT FEES	$ 38,640	17-3	1
2	MARK SUISSA	OWNER	ADMIN	42.32%	SEE ATTACHED	11.14	18.57%	MGT FEES	38,640	17-3	2
3	MARK SUISSA	OWNER	ADMIN	42.32%	SEE ATTACHED	11.14	18.57%	ALLOC HMA	7,414	17-7	3
4	DAVID ARYEH	OWNER	ADMIN	4.70%	SEE ATTACHED	11.11	15.43%	MGT FEES	6,720	17-3	4
5	DAVID ARYEH	OWNER	ADMIN	4.70%	SEE ATTACHED	11.11	15.43%	ALLOC HMA	16,492	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 107,906		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HEALTHCARE MNGMNT. ASSOC.
Street Address: 1401 S. BRENTWOOD BOULEVARD
City / State / Zip Code: BRENTWOOD, MO. 63144
Phone Number: (314) 963-7570
Fax Number: (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. SAL.-NON OWNER	ILL. & MO. PAT. DAYS	312,909	6	$ 226,010	$ 226,010	58,088	$ 41,956	1
2	19	PROFESSIONAL FEES	ILL. & MO. PAT. DAYS	312,909	6	14,970		58,088	2,779	2
3	20	DUES, SUBSCRIPTIONS	ILL. & MO. PAT. DAYS	312,909	6	237		58,088	44	3
4	21	CLERICAL & GENERAL	ILL. & MO. PAT. DAYS	312,909	6	289,405	241,123	58,088	53,725	4
5	24	SEMINAR	ILL. & MO. PAT. DAYS	312,909	6	(1,054)		58,088	(196)	5
6	25	TRAVEL	ILL. & MO. PAT. DAYS	312,909	6	36,045		58,088	6,691	6
7	26	INSURANCE	ILL. & MO. PAT. DAYS	312,909	6	4,460		58,088	828	7
8	27	EMPLOYEE BENEFITS	ILL. & MO. PAT. DAYS	312,909	6	62,557		58,088	11,613	8
9	30	DEPRECIATION	ILL. & MO. PAT. DAYS	312,909	6	6,782		58,088	1,259	9
10	34	OFFICE SPACE	ILL. & MO. PAT. DAYS	312,909	6	64,007		58,088	11,882	10
11	32	INTEREST	ILL. & MO. PAT. DAYS	312,909	6	18		58,088	3	11
12	35	EQUIPMENT RENTAL	ILL. & MO. PAT. DAYS	312,909	6	32,402		58,088	6,015	12
13	10	NURSING SALARIES	ILLINOIS PAT. DAYS	193,423	4	115,413	115,413	58,088	34,660	13
14	15	EMP. BEN. - HEALTH CARE	ILLINOIS PAT. DAYS	193,423	4	19,203		58,088	5,767	14
15	21	CLERICAL SALARIES	ILLINOIS PAT. DAYS	193,423	4	98,498	98,498	58,088	29,580	15
16	27	EMP. BEN. GEN. & ADMIN.	ILLINOIS PAT. DAYS	193,423	4	14,280		58,088	4,288	16
17										17
18	17	ADMIN. SALARY - M. SUISSA	AVG. HOURS WORKED	60	6	39,938	39,938	11	7,414	18
19	17	ADMIN. SALARY - D. ARYEH	AVG. HOURS WORKED	37	4	54,913	54,913	11	16,492	19
20	27	EMP. BEN.-M. SUISSA	AVG. HOURS WORKED	60	6	8,702		11	1,615	20
21	27	EMP. BEN.-D. ARYEH	AVG. HOURS WORKED	37	4	9,847		11	2,957	21
22										22
23										23
24										24
25	TOTALS					$ 1,096,633	$ 775,895		$ 239,372	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CE # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CORUS BANK		X	MORTGAGE-PAID		10/1/95	$ 2,167,000	$ 0		9.00%	$ 79,113	1
2	CIB BANK		X	MORTGAGE	$22,387	6/1/01	3,000,000	2,972,742	11/30/03	VAR	129,449	2
3												3
4												4
5												5
	Working Capital											
6	CORUS BANK		X	LINE OF CREDIT-FINAL				0			16,248	6
7	CIB BANK		X	LINE OF CREDIT		6/1/01		500,000		VAR	21,275	7
8	HUNTER MANAGEMENT	X		WORKING CAPITAL							291	8
9	TOTAL Facility Related				$22,387		$ 5,167,000	$ 3,472,742			$ 246,376	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										16,511	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 16,511	14
15	TOTALS (line 9+line14)						$ 5,167,000	$ 3,472,742			$ 262,887	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CEN # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOCATION-HMA	X					$	$			$ 3	1
2	ASSURANCE AGENCY		X	INSURANCE FINANCING							16,222	2
3	GRAND MANOR	X									286	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 16,511	21

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 85,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 78,978	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,022)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 82,958	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 76,936	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	67,413	8
	1997	72,409	9
	1998	75,485	10
	1999	80,089	11
	2000	78,978	12

2000 TAX * 105% (ESTIMATED INCREASE) = 78,978 * 1.05 = 82,958

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROYAL HEIGHTS NRSG AND REHAB CENTER LLC COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0041228

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08.0-400-007	LONG TERM CARE PROPERTY	$ 78,977.68	$ 78,977.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 78,977.68	$ 78,977.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,378 B. General Construction Type: Exterior BRICK Frame BLOCK Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 237,505	1
2					2
3	TOTALS			$ 237,505	3

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	234		1995	1975	$ 2,172,128	$ 55,696	35	$ 70,069	$ 14,373	$ 437,931	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	28,299		20	1,416	1,416	7,920	9
10	Various			1997	10,691		20	534	534	2,530	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			5,725			(5,725)		69
70	TOTAL (lines 4 thru 69)		$ 2,211,118	$ 61,421		$ 72,019	$ 10,598	$ 448,381	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,211,118	$ 61,421		$ 72,019	$ 10,598	$ 448,381	1
2	ROOF TOP HEATING SYS	1998	1,171		20	59	59	236	2
3	WATER HEATER	1998	8,226		20	411	411	1,644	3
4	HEATING REPAIRS	1998	1,438		20	72	72	282	4
5	PIPE REPAIRS	1998	1,281		20	64	64	251	5
6	NURSE CALL SYSTEM	1998	604		20	30	30	115	6
7	TILE	1998	591		20	30	30	115	7
8	WALK IN COOLER REPAI	1998	647		20	32	32	123	8
9	FIRST FLOOR REPAIRS	1998	1,500		20	75	75	281	9
10	FIRST FLOOR REPAIRS	1998	2,905		20	145	145	544	10
11	ASPHALT	1998	7,500		20	375	375	1,406	11
12	FLOOR TILE	1998	1,345		20	67	67	268	12
13	HVAC REPAIRS	1998	2,045		20	102	102	408	13
14	A/C SERVICE	1998	1,893		20	95	95	356	14
15	REPIPE BOILER ROOM	1998	1,453		20	73	73	268	15
16	REPIPE BOILER ROOM	1998	778		20	39	39	143	16
17	CUBICLE CURTAINS	1998	2,255		20	113	113	414	17
18	TILE REPLACEMENT	1998	558		20	28	28	100	18
19	WALK-IN FREEZE	1998	1,598		20	80	80	293	19
20	POWER MIXING VALVES	1998	986		20	49	49	180	20
21	FREEZER REPAIRS	1998	2,500		20	125	125	438	21
22	CLOSET DOORS	1998	918		20	46	46	157	22
23	SHOWER ROO	1998	13,400		20	670	670	2,122	23
24	OUTDOOR LIGHT POLES	1998	667		20	33	33	105	24
25	A/C UNITS	1998	2,695		20	135	135	540	25
26	A/C UNITS	1998	2,395		20	120	120	470	26
27	AIR CONDITIONER/HEAT	1998	1,210		20	61	61	234	27
28	AIR CONDITIONERS	1998	4,028		20	201	201	804	28
29	A/C WALL UNITS	1998	1,215		20	61	61	239	29
30	A/C WALL UNITS	1998	1,205		20	60	60	230	30
31	A/C WALL UNITS	1998	1,210		20	61	61	234	31
32	A/C UNITS	1998	3,254		20	163	163	557	32
33	A/C UNIT REPAIRS	1998	22,949		20	1,147	1,147	4,206	33
34	TOTAL (lines 1 thru 33)		$ 2,307,538	$ 61,421		$ 76,841	$ 15,420	$ 466,144	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,307,538	$ 61,421		$ 76,841	$ 15,420	$ 466,144	1
2	WALKWAY	1998	4,995		20	250	250	1,042	2
3	CUBICLE CURTAINS	1998	1,374		20	69	69	207	3
4	BLINDS	1999	818		20	41	41	123	4
5	CLOSET DOORS	1999	751		20	38	38	111	5
6	WALLPAPER	1999	608		20	30	30	90	6
7	LOBBY WALLPAPER	1999	645		20	32	32	88	7
8	BATHROOM WALLPAPER	1999	514		20	26	26	69	8
9	WALLPAPER	1999	1,425		20	71	71	183	9
10	BIRCH WOOD DOOR	1999	676		20	34	34	88	10
11	NURSE WALLSTATION	1999	930		20	47	47	137	11
12	DRAPERIES	1999	916		20	46	46	123	12
13	LOBBY TILES	1999	4,912		20	246	246	574	13
14	INSTALL TILE	1999	1,125		20	56	56	131	14
15	A/C UNIT	1999	719		20	36	36	93	15
16	A/C UNITS	1999	2,540		20	127	127	307	16
17	A/C UNIT	1999	1,905		20	95	95	222	17
18	ELECTRICAL CIRCUITS	1999	2,447		20	122	122	295	18
19	ELECTRICALCIRCUITS	1999	1,530		20	77	77	186	19
20	SMOKING ROOM	1999	26,516		20	1,326	1,326	4,038	20
21	WALLPAPER	2000	10,150		20	508	508	804	21
22	WALLPAPER	2000	9,432		20	472	472	747	22
23	DRAPERIES	2000	11,232		20	562	562	890	23
24	AUTO DOOR LOCKS	2000	624		20	31	31	41	24
25	AIR CONDITIONER	2000	2,193		20	110	110	183	25
26	WALLCOVERINGS	2001	29,475		20	1,228	1,228	1,228	26
27	ROOFING	2001	15,595		20	650	650	650	27
28	WALLCOVERINGS	2001	5,306		20	199	199	199	28
29	WALLCOVERINGS	2001	1,530		20	64	64	64	29
30	ELECTRICAL	2001	3,638		20	137	137	137	30
31	WANDERGUARD	2001	612		20	5	5	5	31
32	WALL AC UNIT	2001	1,462		20	73	73	73	32
33	STORAGE SHED	2001	800		20	40	40	40	33
34	TOTAL (lines 1 thru 33)		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,454,933	$ 61,421		$ 83,689	$ 22,268	$ 479,312	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER I# 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 582,327	$ 61,433	$ 56,769	$ (4,664)	10	$ 343,941	71
72	Current Year Purchases	6,654		462	462	10	462	72
73	Fully Depreciated Assets	960				10	960	73
74								74
75	TOTALS	$ 589,941	$ 61,433	$ 57,231	$ (4,202)		$ 345,363	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,282,379	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	122,854	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	140,920	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	18,066	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	824,675	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	ALLOCATION-HMA				11,883			6
7	TOTAL				$ 11,883 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 21,794 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2000 VOLVO (S80)	$ 623	$ 4,361	17
18					18
19					19
20					20
21	TOTAL		$ 623	$ 4,361	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 5,684	$		$ 5,684	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,787			3,787	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			19,812			19,812	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				18,618		18,618	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						9,520		9,520	13
14	TOTAL			$		$ 29,283	$ 28,138		$ 57,421	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 18,195	$ 20,515	1
2	Cash-Patient Deposits	350	350	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,219,415	1,219,415	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	156,019	156,019	6
7	Other Prepaid Expenses	3,281	3,281	7
8	Accounts Receivable (owners or related parties)	144,271	1,231,518	8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,541,531	$ 2,631,098	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,505	13
14	Buildings, at Historical Cost		2,172,127	14
15	Leasehold Improvements, at Historical Cost	236,086	236,086	15
16	Equipment, at Historical Cost	151,996	619,996	16
17	Accumulated Depreciation (book methods)	(129,681)	(912,608)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		14,206	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 258,401	$ 2,367,312	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,799,932	$ 4,998,410	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,036,341	$ 1,036,341	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,094	29,094	28
29	Short-Term Notes Payable	500,000	500,000	29
30	Accrued Salaries Payable	91,733	91,733	30
31	Accrued Taxes Payable (excluding real estate taxes)	40,461	40,461	31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,958	82,958	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,000	3,000	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,783,587	$ 1,783,587	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,972,742	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,972,742	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,783,587	$ 4,756,329	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 16,345	$ 242,081	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,799,932	$ 4,998,410	48

*(See instructions.)

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 220,937	1	
2	Restatements (describe):		2	
3	RESTATEMENT OF PRIOR YEAR INCOME	(65,031)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 155,906	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	467,923	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(607,484)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (139,561)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 16,345	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,959,455	1
2	Discounts and Allowances for all Levels	143,231	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,102,686	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	20,597	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 20,597	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	267	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	30,988	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 31,255	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See supplemental schedule	4,549	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,549	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,159,087	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,235,252	31
32	Health Care	1,551,114	32
33	General Administration	1,259,167	33
	B. Capital Expense		
34	Ownership	458,354	34
	C. Ancillary Expense		
35	Special Cost Centers	59,162	35
36	Provider Participation Fee	128,115	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,691,164	40
41	**Income before Income Taxes (line 30 minus line 40)****	467,923	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 467,923	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,005	1,005	$ 26,082	$ 25.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,861	10,861	193,321	17.80	3
4	Licensed Practical Nurses	26,241	26,241	401,491	15.30	4
5	Nurse Aides & Orderlies	81,280	81,280	564,826	6.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,134	1,134	11,338	10.00	9
10	Activity Assistants	7,246	7,246	52,825	7.29	10
11	Social Service Workers	13,308	13,308	130,148	9.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,266	24,266	196,309	8.09	15
16	Dishwashers					16
17	Maintenance Workers	16,903	16,903	114,263	6.76	17
18	Housekeepers	39,187	39,187	222,192	5.67	18
19	Laundry	14,896	14,896	80,290	5.39	19
20	Administrator	1,955	1,955	46,333	23.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,915	14,915	51,172	3.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,285	3,285	27,334	8.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	256,482	256,482	$ 2,117,924 *	$ 8.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	200	$ 7,831	01-03	35
36	Medical Director	MONTHLY	10,000	09-03	36
37	Medical Records Consultant	MONTHLY	1,715	10-03	37
38	Nurse Consultant	67	4,050	10-03	38
39	Pharmacist Consultant	18	1,125	10-03	39
40	Physical Therapy Consultant	120	7,643	10a-03	40
41	Occupational Therapy Consultant	80	5,195	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	80	5,042	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	55	3,715	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	620	$ 46,316		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER I # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
K HOLLINGSHEAD(1/1-1/17/01)	ADMINISTRATOR	0.00%	$ 4,038
CLARA RICH (2/1-12/31/01)	ADMINISTRATOR	0.00%	42,295
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 46,333

B. Administrative - Other

Description	Amount
MANAGEMENT FEES-ERIC ROTHNER	$ 38,640
MANAGEMENT FEES-MARK SUISSA	38,640
MANAGEMENT FEES-DAVID ARYEH	6,720
HOME OFFICE EXPENSES	284,358
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 368,358

C. Professional Services

Vendor/Payee	Type	Amount
DUANE MORRIS HECKSHER	LEGAL	$ 21,786
BKD	ACCOUNTING	5,883
FR&R	ACCOUNTING	27,348
THRESHOLD	COMPUTER SERVICES	1,737
CARE SYSTEM	COMPUTER SERVICES	1,363
MEDICOM	COMPUTER SERVICES	153
BKD-REV PY OVERACCURAL	ACCOUNTING	(14,191)
PERSONNEL PLANNERS	UC TAX CONSULTANT	1,724
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 45,803

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,086
Unemployment Compensation Insurance	64,006
FICA Taxes	160,279
Employee Health Insurance	19,020
Employee Meals	7,512
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS	31,620
401 (K) EXPENSE	202
TOTAL (agree to Schedule V, line 22, col.8)	$ 352,725

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	17,202
Health Care Worker Background Check	846
(Indicate # of checks performed 37)	
ADVERTISING	6,152
DUES & SUBSCRIPTIONS	530
LICENSES & FEES	4,632
ALLOCATION-HMA	44
Less: Public Relations Expense	
Non-allowable advertising	(6,152)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,454

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,388
ALLOCATION-HMA	(196)
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,192

**See instructions.

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING & DÉCOR	06/97	$ 10,038	3	$ 3,346	$ 3,346	$ 1,673	$	$	$	$	$	$
2													
3													
4													
5													
6													
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17													
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19													
20	TOTALS		$ 10,038		$ 3,346	$ 3,346	$ 1,673	$	$	$	$	$	$

Facility Name & ID Number ROYAL HEIGHTS NRSG AND REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **859** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **128,115**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,512** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees